

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02143500

### 1. PLACE OF DEATH:

County..... Worcester  
City or town..... Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 42 years  
Hospital, institution, or street address where death occurred  
811 Walnut Street  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Md. County..... Worcester  
City or town..... Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 811 Walnut Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Asbury P. Beauchamps

### 3. (b) Social Security Number

4. Sex..... Male  
5. Color or race..... White  
6. (a) Single, married, widowed, or divorced..... Widowed  
6. (b) Name of husband or wife..... Lussie Beauchamps

7. Birth date of deceased (mo., day, yr.)..... April 14, 1865  
6. (c) If alive, give age..... years

8. AGE: Years..... 81 Months..... 10 Days..... 2  
If less than one day..... hrs. .... min.

9. Birthplace..... Worcester County - Maryland  
(Town, county, and state)  
10. Usual occupation..... Mail Carrier (rural)

11. Industry or business

12. Name..... Levin W. Beauchamps

13. Birthplace..... Worcester County Md

14. Maiden name..... Sallie Holland

15. Birthplace..... Worcester County, Md

16. Informant..... Mrs. Margaret Wood

Address..... Pocomoke City, Md

17. Burial (Burial, cremation, or removal, which?)..... Date thereof..... Feb. 18, 1947  
(month) (day) (year)  
Cemetery or crematory..... Bethany Methodist Cem.  
Location..... Pocomoke City, Md

18. Funeral director..... W. Harvey Boudshaw  
Address..... Pocomoke City, Md

19. Date rec'd by registrar..... Feb. 19, 1947  
Registrar..... Ann E. White

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 16th 1947, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23rd 1947 to Feb 16th 1947 and that I last saw him alive on Feb 16th 1947

Immediate cause of death..... Coronary Occlusion  
DURATION..... Sudden death

Due to..... Coronary Insufficiency 2 years

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....  
Means of injury..... Injured at work?

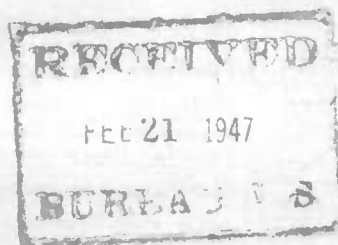
23. SIGNATURE..... J. K. Astorius M.D.  
Address..... Pocomoke City, Md  
Date signed..... 2/18/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02142

3570

## 1. PLACE OF DEATH:

County Worcester  
 City or town Snowsfall md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred: no  
 How long in hospital or institution? no

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Worcester  
 City or town Snowsfall md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1 Ross  
 (If rural, give LOCATION) no  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Lewis Barton

## 3. (b) Social Security Number

no

4. Sex male 5. Color or race a.a. 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Ada R. Barton  
Dead 6.(c) If alive, give age no years  
 7. Birth date of deceased (mo., day, yr.) about 1884  
 8. AGE: Years about 63 Months - Days - If less than one day - hrs. - min.

9. Birthplace Snowsfall  
 (Town, county, and state)

10. Usual occupation  Carpenter

11. Industry or business Same as above

12. Name William Lewis

13. Birthplace Worcester md

14. Maiden name Maudiea Hentry

15. Birthplace Snowsfall md

16. Informant Alton Barton

Address Snowsfall md

17. Burial, cremation, or removal. Which? Burial Date there? Feb 19-1947  
 (month) (day) (year)

Cemetery or crematory Ebenezer

Location Snowsfall md

18. Funeral director James H. Stewart

Address Salisbury md

19. 3/19/47 LeRoy Smith  
 (date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Feb 19 47 at 6 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1, 19 46, to 17 Feb 19 47

and that I last saw him alive on 16 Feb 19 47

Immediate cause of death Carcinoma

of Rectum DURATION 4 yrs

Due to -

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE Hermona K. K. K. M. D. or other -

Address Berlin, md Date signed 18 Feb 47

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FEB 21 1947

BUREAU V S

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3570

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Snow Hill Md R.R. No. 1  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? about 29 years  
 Hospital, institution, or street address where death occurred: no  
 How long in hospital or institution? no

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery  
 City or town Snow Hill R.R. No. 1  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. no  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

James E. Cohen

## 3. (b) Social Security Number

no

4. Sex Male 5. Color or race a.a. 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Ella J. Cohen  
 7. Birth date of deceased (mo., day, yr.) about 1883 6. (c) If alive, give age Don't know years  
 8. AGE: Years about 64 years Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Withams n.a.  
 (Town, county, and state)

10. Usual occupation farmer

11. Industry or business Same as above

12. Name George Cohen

13. Birthplace Withams n.a.

14. Maiden name Caroline Broadwater

15. Birthplace Withams n.a.

16. Informant Spencer Cohen

Address Snow Hill Md

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Feb 23-1947  
 (month) (day) (year)

Cemetery or crematory St. Wesley

Location near Snow Hill

18. Funeral director James H. Stewart

Address Salisbury Md

19. 2/19/47 LeRoy Smith  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 19 47 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 19 46 to Feb 18 19 47  
 and that I last saw him alive on Feb 17 19 47

Immediate cause of death Cerebral Vascular accident DURATION 7 DAYS

Due to Hypertensive Cardiovascular  
Renal syndrome 10 yrs.

Due to no

Other conditions no

(Include pregnancy within 3 months of death)

Major findings of operations no

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of no

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) no

Means of injury no Injured at work? no

23. SIGNATURE Robert L. La Mar M.D. M. D. or other

Address Snow Hill Date signed 2-18-47

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 21 1947

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

### 1. PLACE OF DEATH:

County Montgomery  
City or town McConah's City  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town McConah's City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION) 70  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Emma F. Davis

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

### 6. (b) Name of husband or wife

Joseph Davis

### 7. Birth date of deceased (mo., day, yr.)

March 12 - 1880

8. AGE: Years 66 Months 10 Days 25 If less than one day  
hrs. min.

9. Birthplace New Church, Orange, Virginia  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name John H. Simon

13. Birthplace Virginia

14. Maiden name Esther J. Aydelette

15. Birthplace Maryland

16. Informant Mrs. Marie S. McFar

Address McConah's City, Md

17. Funeral Date thereof Feb 9/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Remond

Location McConah's City, Md

18. Funeral director May E. Davis

Address Montell Md

19. Feb 10 19 47 Anne E. White  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 19 47 at 3:57 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8 19 46 to Feb 7 19 47  
and that I last saw her alive on Feb 7 19 47

Immediate cause of death Carcinoma of Stomach with metastasis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accidental, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis S. Claudym, M.D.  
Address Pocomoke City Date signed 2-8-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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FEB 12 1947

BOSTON

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Dr. Hedrich:

The attached certificate of death was delivered to me today by a messenger sent by the Undertaker, Mr. Clay E. Dennis. I do not know the reason for the delay. The permit was issued as of today.

A. White

2/10/47

O.C. - Salis. Rd.

city in summer.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170a

## CERTIFICATE OF DEATH

Reg. Dist. No. 8550

## 1. PLACE OF DEATH:

County Worcester  
 City or town Berlin  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 year  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Massachusetts County Dussan  
 City or town Millisboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Russell W. Dennis

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Wilma Dennis

6. (c) If alive, give age 24 years  
 7. Birth date of deceased (mo., day, yr.) July 24, 1915

8. AGE: Year 31 Months 6 Days 8 If less than one day  
 hrs. min.

9. Birthplace Covington, Ind.  
 (Town, county, and state)

10. Usual occupation Chicken raiser

11. Industry or business John Dennis

12. Name John Dennis

13. Birthplace Covington

14. Maiden name Ella Smith

15. Birthplace Maryland

16. Informant Tracy Dennis

Address Worcester, Ind.

17. Burial, cremation, or removal Buried Date thereof 2/4/47  
 (month) (day) (year)

Cemetery or crematory Trinity

Location Woods R 2D Mt

18. Funeral director Anna A. Burbage

Address Berlin Ind.

19. 2-4- 19 47 John F. Hayward  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 47 at 11:59 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19 to 19

and that I last saw him alive on 19

Immediate cause of death Fractured skull

Due to Struck by train

Due to Driver of car

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 2/1/47

Where did injury occur? Berlin Worcester, Ind.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home 2/1/47

Means of injury Struck by train Injured at work? No

23. SIGNATURE John F. Hayward M. D. or other

Address Berlin Ind. Date signed 2/1/47

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FEB 8 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

486

02146

## CERTIFICATE OF DEATH

Reg. Diat. No. 3530

## 1. PLACE OF DEATH:

County Worcester  
 City or town Bishop Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Worcester  
 City or town Bishop Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Jennie Fassitt

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced \_\_\_\_\_  
 6.(b) Name of husband or wife Charlie Fassitt 6.(c) If alive, give age 66 years  
 7. Birth date of deceased (mo., day, yr.) — 1886

8. AGE: Years 60 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Worcester Co.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Herry Williams13. Birthplace MD.14. Maiden name Liza Armstrong15. Birthplace MD.16. Informant Charlie FassittAddress Bishop, MD.17. Buried Date thereof 2-28-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sarah Dukes Cem.Location near Bishop, MD.18. Funeral director Herry S. WatsonAddress Pocomoke City, MD.19. 2/28/47 Mary Berg  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 19 47, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 19 46, to Feb 26 19 47  
 and that I last saw him alive on Feb 25 19 47

Immediate cause of death \_\_\_\_\_ DURATION

Cardiovascular system  
multiple metastasis  
1 yr.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

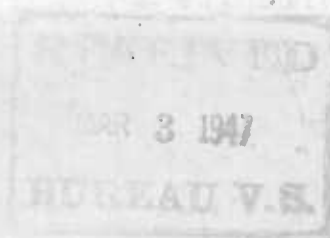
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Arant S. Long M.D. M. D. or otherAddress Frankford Ave Date signed 2-22-47



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B-2*

## CERTIFICATE OF DEATH

Reg. Diat. No.

02147

3500

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (A) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

19.

Anne E. White

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

February 27, 1947, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

January 27, 1947, to February 27, 1947,

and that I last saw him alive on February 25, 1947.

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 2/28/47



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-27

## CERTIFICATE OF DEATH

Reg. Dist. No. 3510

## 1. PLACE OF DEATH:

County..... Worcester  
 City or town..... Snow Hill Rural #1  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Worcester  
 City or town..... Snow Hill Rural #1  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2(a) If veteran, name war..... No

## 3. (a) FULL NAME

George B. Harmon

## 3. (b) Social Security Number

218-16-5886

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Laura C. Harmon

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age 48 years

May 2 - 1879

8. AGE: Years 67 Months 9 Days 19 hrs. min.

9. Birthplace Newark, Worcester, Md

10. Usual occupation Farmer

11. Industry or business

12. Name Edward Harmon

13. Birthplace Maryland

14. Maiden name Unknown

15. Birthplace

16. Informant Mr. George Harmon Jr

Address Snow Hill, Md Rural #1

17. Burial (Burial, cremation, or removal, Which?) Date thereof Feb 24/47 (month) (day) (year)

Cemetery or crematory Harmon Rural #1

Location Newark, Md

18. Funeral director Delaney &amp; Dennis

Address Snow Hill, Md

19. 2/24/47 1947 24 Day Smith Registrar (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1947 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/11/47 19 to 2/21/47 19 and that I last saw him alive on 2/20/47 19

Immediate cause of death Hypertensive Cardio-vascular renal disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

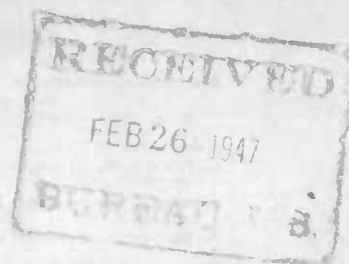
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Cohen M.D.

Address Snow Hill Date signed 2/22/47



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

## CERTIFICATE OF DEATH

Reg. Dist. No.

02149

3500

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month)

(day)

(year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

47

Anne E. White

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 3

19

47

at

8:25 P.

M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 26th 47 to Feb 3rd 47

and that I last saw him alive on Feb 2nd 1947

Immediate cause of death

DURATION

Due to

Due to

Other conditions

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

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FEB 8 1947

BUREAU VV

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02150

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 3540

## 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Henry P. Hickman  
 4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Margie D. Hickman  
 7. Birth date of deceased (mo., day, yr.) July 23 - 1886  
 6.(c) If alive, give age 67 years

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1947 at 12:20 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945 to Feb 16 1947  
 and that I last saw him alive on February 15 1947

## Immediate cause of death

Pulmonary Tuberculosis 18 mo

## Due to

## Due to

## Other conditions Arthritis

(Include pregnancy within 8 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Paul Cohen M.D.  
 M. D. or other

Address..... Snow Hill Date signed 2/17/47

9. Birthplace.....  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name John T. Hickman

13. Birthplace Virginia

MOTHER 14. Maiden name Sarah Russell

15. Birthplace Virginia

16. Informant Mary E. Dennis

Address Snow Hill, Md.

17. (Burial, cremation, or removal, which?) Date reported Feb 18/47

Cemetery or crematory.....

Location.....

18. Funeral director Mary E. Dennis

Address Snow Hill, Md.

19. Feb 17 1947 Mary M. Taylor Registrar

(Date rec'd by registrar)

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

355

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal—Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

16. Funeral director

Address

19.

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 9

1947

at

10 a.

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Coronary thrombosis

DURATION

Few

minutes

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

82

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1894-1895

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FEB 12 1947  
BUREAU V B.

FEB 12 1947

BUREAU V B

W-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 36

## CERTIFICATE OF DEATH

Reg. Dist. No. 3510

## 1. PLACE OF DEATH:

County... Wicomico  
 City or town... Snow Hill, Rural #1  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 32 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Wicomico  
 City or town... Snow Hill, Rural #1  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No...  
 (If rural, give LOCATION)  
 2(a) If veteran, name war... World War I

## 3. (a) FULL NAME

Paul M. Johnson

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

4. (b) Name of husband or wife  
 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/4/94

8. AGE: Years 52 Months 6 Days 11 It less than one day hrs. min.

9. Birthplace Snow Hill, Wicomico, Md  
 (Town, county, and state)

10. Usual occupation Shaver

11. Industry or business

FATHER 12. Name Samuel Johnson

13. Birthplace Maryland

MOTHER 14. Maiden name Maggie Johnson

15. Birthplace Maryland

16. Informant Herman Johnson

Address Snow Hill, Md

17. Burial, cremation, or removal, Which? Burial Date thereof Oct 18/47  
 (month) (day) (year)

Cemetery or crematory Butte Chapel

Location Snow Hill, Md

18. Funeral director Way C. Dammis

Address Snow Hill, Md

19. 3915 47 Re Roy Smith  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 19 47 at 1 10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 44 to Feb 15 19 47  
 and that I last saw him alive on Feb 14 19 47

Immediate cause of death Acute Pulmonary Edema DURATION 1 wk

Due to Hypertensive Cardiac

vascular renal syndrome 10 yrs.

Due to

Other conditions sypilis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert L. La Mar, MD M. D. or other

Address Snow Hill Date signed 2-15-47

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FEB 19 1947  
BUREAU

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3570

## 1. PLACE OF DEATH

County Worcester  
 City or town Priddeston Rural #1  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 60 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Worcester  
 City or town Priddeston  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war 70

## 3. (a) FULL NAME

Priscilla Johnson  
 4. Sex Female 5. Color or race Irish 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife John M. Johnson

7. Birth date of deceased (mo., day, yr.) Nov. 15 - 1866 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 80 Months 3 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Shrewsbury, Worcester, Md  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Isaac Butler

13. Birthplace Maryland

MOTHER 14. Maiden name Unknown

15. Birthplace \_\_\_\_\_

16. Informant Rev. Ernest J. Johnson

Address Worcester, Md

17. Burial, cremation, or removal. Which? Burial Date thereof Feb 23/47  
 (month) (day) (year)

Cemetery or crematory Local Springs

Location near Priddeston

18. Funeral director Wm. C. Dennis

Address Shrewsbury, Md

19. 2/22/47 Registrar LeRoy Smith  
 (Date rec'd by registrar)

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1947 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_\_,

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_\_,

Immediate cause of death Myocardial degeneration  
of heart

Due to \_\_\_\_\_ DURATION \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John L. Riley M.D. and Exam

M. D. or other \_\_\_\_\_

Address Shrewsbury, Md Date signed 2/19/47



1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02154

Reg. Dist. No. 3550

## 1. PLACE OF DEATH:

County WorcesterCity or town Shawville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 yrs

Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Shawville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Annie Emma McCobe

## 3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Leslie J. McCobe7. Birth date of deceased (mo., day, yr.) July 10 18708. (c) If alive, give age 86 years8. AGE: Years 76 Months 7 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Joe Emma13. Birthplace Bethesda Md14. Maiden name Catherine Emma15. Birthplace Bethesda Md16. Informant Eliabeth ClarkAddress Wilmington Del.17. Buried Date thereof Feb. 14, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory 1007 CemeteryLocation Bethesda Md18. Funeral director M. Paula WatsonAddress Shawville Md19. 2-13 47 Helen F. Hayward  
(Data rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 19 47 at 3:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_\_,

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_\_,

Immediate cause of death Symptomatic degeneration of the heart

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

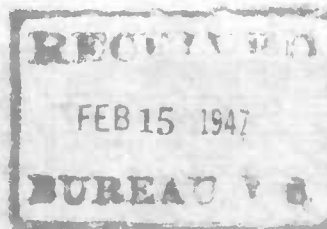
23. SIGNATURE John L. Riley M.D. Exam

M. D. or other

Address Shawville Md Date signed 2/14/47



*Mrs. Watson*



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

## CERTIFICATE OF DEATH

02155

Reg. Dist. No.

3510

## 1. PLACE OF DEATH:

County... WorcesterCity or town... Spindale  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WorcesterCity or town... Spindale  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war

70

## 3. (a) FULL NAME

Ellen Turner

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

Ireland

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

William Turner

## 7. Birth date of deceased (mo., day, yr.)

Oct. 6 - 19066.(c) If alive, give age 40 years

## 8. AGE:

40 Years4 Months3 Days

If less than one day

...hrs. ...min.

## 9. Birthplace

Accomack City, Worcester, Md  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Own home

## MOTHER FATHER

## 12. Name

Maun Barton

## 13. Birthplace

Maryland

## 14. Maiden name

Adeline Rowley

## 15. Birthplace

Maryland

## 16. Informant

Gussie E. Barton

## Address

Spindale, Md

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

Feb 12/47  
(month) (day) (year)

## Cemetery or crematory

Union Bethel

## Location

Accomack City, Md

## 18. Funeral director

Walter E. Dennis

## Address

Spindale, Md

## 19.

29/29  
(Date rec'd by registrar)

## 19.

47ReDay Smith  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1947 at 2:16 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 8 1947, to Feb 9 1947and that I last saw him/her alive on Feb 8 1947

## Immediate cause of death

Status epilepticus

## DURATION

1 day

## Due to

Epilepsy1 year

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

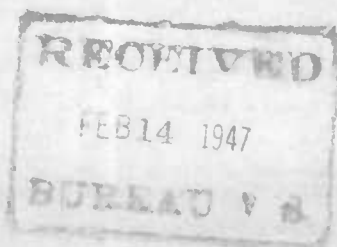
Injured at work?

## 23. SIGNATURE

Paul E. W.D.  
Snow Hill

M. D. or other

Address Date signed 2/11/47



F 35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

## CERTIFICATE OF DEATH

02156

Reg. Dist. No. 3500

## 1. PLACE OF DEATH:

County Worcester  
 City or town Pocomoke city  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 68  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MD County Worcester  
 City or town Pocomoke city  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Edward J Victory  
 4. Sex Male 5. Color or race Cal 6.(a) Single, married, widowed, or divorced widower  
 6.(b) Name of husband or wife Sadie Victory  
 6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 15 - 1878

8. AGE: Years 68 Months 7 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pocomoke City, Worcester Co, Md  
 (Town, county, and state)

10. Usual occupation RR Rail Road worker

## 11. Industry or business

FATHER 12. Name Edben Victory  
 13. Birthplace Pocomoke City

MOTHER 14. Maiden name Mary unknown  
 15. Birthplace Pocomoke City Md

16. Informant Mrs Helen Wastes  
 Address Marion sta Md RD 1 box 104

17. Burial Date thereof Feb 9, 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mount Zion  
 Location Pocomoke city Md

18. Funeral director Chas H Ward  
 Address Marion sta Md

19. Feb 7 19 47 Anne E White  
 (Date rec'd by Registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1947 at 4:37 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 1947 to Feb 6 1947 and that I last saw him alive on Feb 5 1947

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Paralysis 3 days

Due to Stroke 9 days

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. E. Antorus MD  
 Address Pocomoke City Md Date signed 2/6/47  
 M. D. or other \_\_\_\_\_

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FEB 10 1947

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02157

Reg. Dist. No. 350

1. PLACE OF DEATH: Worcester  
County Rural, Pocomoke, Md.  
City or town Lifetime  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Unionville Road  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Worcester  
City or town Rural, Pocomoke  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Unionville Road  
(If rural, give LOCATION)  
2. (a) If veteran, name war

3. (a) FULL NAME  
Sara Jane Waters

3. (b) Social Security Number

4. Sex Female  
5. Color or race Colored  
6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Alonzo Waters

6. (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) April 22, 1890

8. AGE: Years 56 Months 9 Days 22 If less than one day  
.....hrs. ....min.

9. Birthplace Pocomoke-Worcester-Maryland  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Stephen Schoolfield

13. Birthplace Pocomoke, Md.

14. Maiden name Eliza Robinson

15. Birthplace Pocomoke, Md.

16. Informant Alonzo Waters

Address Unionville, Pocomoke, Md.

17. Burial Date thereof Feb 17, 1947  
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Unionville Cemetery

Location Rural, Pocomoke, Md.

18. Funeral director H. Harvey Bradshaw

Address Pocomoke, Maryland

19. Feb 25, 1947 Anne E. White  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1947, at 12.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 11, 1947, to Feb. 14, 1947.

and that I last saw her alive on Feb. 14, 1947.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertensive Cardio-vascular Disease.

Due to Nephritis.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis J. Clewelyn MD

Address Pocomoke City M. D. or other

Date signed 2-18-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The postage is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

## CERTIFICATE OF DEATH

Reg. Dist. No. 02158 3510

## 1. PLACE OF DEATH:

County At Sea WorcesterCity or town (Outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State North Carolina CountyCity or town Rocky Mount

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1304 Boone Street

(If rural, give LOCATION)

2.(a) If veteran, name war World War 2.

## 3. (a) FULL NAME

William Randolph Weeks

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White US

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

February 17, 1923

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

23 11 18 hrs. min.9. Birthplace Rocky Mount, North Carolina

(Town, county, and state)

10. Usual occupation U. S. Navy

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Health RecordAddress Bureau of Med. & Surg. Wash. DC17. Removal Date thereof 2-25-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 2/25/47 Ray Smith(Date rec'd by registrar) 19 47 Ray Smith RegistrarJames Hill, md

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4 February 19 47 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 25 19 47 to 19

and that I last saw h. alive on 19

Immediate cause of death Injuries MultipleExtreme (Decapitation)

DURATION

Due to Aircraft Accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 2-4-47Accident, suicide, or homicide Accident Date ofWhere did injury occur? At Sea

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At SeaMeans of injury Fatal Injured at work? YesSignature D. J. Pontarelli, LCDR, (MC) USNAddress NAAS Chincoteague, Va M. D. or otherDate signed 2-25-47



